**Ontario
Palliative Care
Network**

<u>**Planning for Palliative Care Delivery during the COVID-19 Pandemic**</u>

Palliative care providers, along with all health care providers, are now in the midst of delivering care in the context of the COVID-19 pandemic. Palliative care is an essential component in pandemic planning.

This document is for palliative care clinicians and programs and the intent is to:
- Outline some of the key issues in planning for palliative care delivery in the context of COVID-19
- Share some considerations and resources to draw on for guidance in planning at the local level.

*NOTE: The content in this document is based on information available as of March 24, 2020.*

**It is imperative that all planning is done in alignment and collaboration with regional and institutional bodies to ensure approaches are consistent with emerging provincial and regional planning and directives.**

In addition to this document, the Ontario Palliative Care Network[1] has also developed *"Palliative Care Resources to Support Frontline Providers during the COVID-19 Pandemic"* which summarizes some of the readily available tools and resources. The Regional Palliative Care Network (RPCN) directors and clinical co-leads can also be a valuable resource for guidance and access to clinical tools. **Please reach out to Info@ontariopalliativecarenetwork.ca to obtain contact information for your local RPCN leadership team**.

### Prioritizing Palliative Care Delivery
In the time of a pandemic, we need to plan palliative care delivery for two populations:
1. Patients with progressive, life-limiting conditions (individuals who would traditionally be identified as having palliative care needs where palliative care is the primary focus of their care or where palliative care is part of their overall care plan).
2. Patients who become rapidly and terminally ill as a result of COVID-19.

If resources become constrained, it may become important to prioritize patients; identifying those who are most in need of care and those for whom some care provision can be deferred or delayed. Modeling Cancer Care Ontario's approach in establishing three priority levels for cancer care during a pandemic including those receiving palliative care and end-of-life care, the following priority groups have been refined and expanded to be disease-agnostic. These priorities can be considered for any diagnosis or care setting and can be used to support triaging new referrals to palliative care services:

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[1] The Ontario Palliative Care Network is a partnership of community stakeholders, health service providers and health systems planners who are developing a coordinated and standardized approach for delivering hospice palliative care services in the province. We are funded by the Ministry of Health to help deliver on Ontario's commitment to palliative care.

**Ontario Health**

**Planning for Palliative Care Delivery during the COVID-19 Pandemic**

a.  **Priority A**
    I.      Severe or uncontrolled symptoms.
    II.     Serious or life-threatening complications of illness that are likely to be reversible[2] in patients with a Palliative Performance Scale (PPS)[3] > 30% and goals of care that support intervention
    III.    Transitioning to or at end-of-life (including those dying of COVID-19)
    IV.     Caregiver crisis due to illness in family or frontline care providers (e.g. Personal Support Workers)

    Priority A patients are more likely to require direct, in-person care regardless of setting. Screening for COVID-19 is imperative as the first step for all direct care. These patients will require more urgent conversations about their goals and plan of care. They may be more likely to require care in an alternative setting such as a hospital, palliative care unit (PCU), or hospice residence[4].

b.  **Priority B**
    I.      Moderate severity symptoms
    II.     Complications of illness that can be managed in the community
    III.    Psychological distress for the patient, family or caregiver
    IV.     Caregiver loss or burnout

    Priority B patients usually can be managed in their current setting either by direct, in person care or virtually. These will be patients for whom use of virtual care options – telephone, virtual visits, text messaging - will be most beneficial and efficient.

c.  **Priority C**
    I.      Stable or mild symptoms
    II.     PPS > 60%
    III.    Planned for routine follow-up

    Priority C patients may continue with their current care plan and have routine follow-up visits deferred. These patients should have clear information about what changes in their health status they should be monitoring and how to access care should any of these changes occur. Virtual care options will be particularly valuable if contact with these patients is required.

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[2] When patients with palliative care needs are identified early in the course of illness, treatment of serious or life-threatening complications of their illnesses can be very appropriate. While palliative care providers may not be responsible for providing these treatments, they may receive calls from these patients and/or be involved in helping to make decisions about care and providing direction to patients/families or other health care providers.
[3] Palliative Performance Scale: https://www.ontariopalliativecarenetwork.ca/sites/opcn/files/VictoriaHospice-PPSScaleTool.pdf
[4] Hospice residences may not be able to accommodate patients with COVID-19 at this time

**Planning for Palliative Care Delivery during the COVID-19 Pandemic**

**Human resources**

One of the key issues in managing human resources will be making the most efficient and effective use of specialist palliative care providers and ensuring that primary level/frontline providers have access to the tools and supports they need to provide good primary level palliative care. Some of the important considerations will be:

- Within palliative care programs establishing a triage function for identifying those patients in most need of care (as per the priorities above) and for whom specialist care or consultation may be required.
- A standardized and transparent decision-making process for palliative care specialists to ensure effective deployment of specialized resources to the highest priority patients.
- Regular risk assessment to identify where clinician shortages are occurring due to clinician illness or self-isolation.
- Identifying for each setting of care (e.g. hospital, Long-Term Care (LTC), community, etc.) which palliative care specialists are available to provide direct care, consultation or provider support.
- Establishing clear, accessible linkages between palliative care specialist clinicians and programs with local primary care providers and long term care homes. RPCNs can be a valuable resource for facilitating these connections.
- Planning and implementation of virtual care resources (telephone, email/text, virtual visits) for patient care. Refer to this document for guidance: https://quorum.hqontario.ca/Portals/0/Users/170/54/10154/Draft%20Clinical%20Guidance_Adopting%20and%20integrating%20virtual%20visits%20into%20care_V1.pdf?ver=2020-03-13-091936-370
- Ensuring that frontline clinicians have ready access to tools (may include symptom management guides /standard order sets, guides to goals of care are COVID-19 communication guides and consultation). Refer to the OPCN's document *"Palliative Care Resources to Support Frontline Providers during the COVID-19 Pandemic"* for a helpful summary of tools.
- Planning for the use of telephone and digital approaches to provide support to the frontline providers

**Access to beds**

It can be expected that an additional demand for beds to care for patients with palliative care needs will occur during the pandemic. These increased demands will occur due to:

- Increased volumes of patients in hospital dying as a result of COVID-19
- Increased volume of patients in LTC dying as a result of COVID-19
- Patients at home who need to transition to an alternative setting as a result of acute caregiver illness or a critical loss of clinical homecare staff including Personal Support Workers (PSWs)

Planning for bed allocations should be done in close coordination with regional and institutional planning bodies. Some important elements to consider will be:

- Proactive conversations with patients and their families and caregivers about the current context and the pressures on hospitals and emergency departments. A sensitive discussion

March 24, 2020

about how this context may affect decisions regarding their care and what their goals and preferences would be in this context. Refer to the OPCN's document *"Palliative Care Resources to Support Frontline Providers during the COVID-19 Pandemic"*, specifically the section on *"Support for Difficult Discussions, and Crisis Communication"* for relevant tools

- Within hospitals, planning for how designated palliative care beds will be used during the pandemic and ensuring optimal utilization of these beds.
- Planning for the accommodation of patients who have severe illness due to COVID-19 and will not receive aggressive life support.
- Within long term care homes, a similar planning for dying due to COVID-19 particularly where patients are not in private rooms.
- On a longer-term basis, consideration of establishing alternative beds for palliative care for patients in the community. This might include expansion of hospice beds or conversion of other beds for palliative care.
- It will also be important to plan for the possibility that patients in existing beds, e.g. PCU, hospice or at home, become COVID-19 positive or are under-investigation.

## Access to medications and equipment

Over the course of the pandemic it will be important to plan for the possibility of constraints on the supply chain for medications and equipment. These may be most notable in community or hospice settings. Some important elements of a plan will be:

- In community, hospice and LTC settings, ensure that patients have adequate supplies of prescribed medications. Please refer to Health Canada's recent guidance document for clarification on activities that are currently permitted under the Controlled Drugs and Substances Act and its Regulations: https://content.oma.org/wp-content/uploads/private/CDSA-Exemption-and-interpretive-guide-for-controlled-substances-intro-DG.pdf
- In these same settings, ensure adequate supplies of "rescue medications" that might be needed to manage a symptom crisis or end-of-life care. This may entail a review of the protocols for "symptom management kits" in community settings but should also be done in concert with regional plans to a balance approach to the supply of essential medications.
- In these same settings, establish a list of critical equipment and supply needs and ensure adequate supplies. This may require some level of prioritization of needs.
- In hospitals, ensure adequate supplies of medications needed to manage end-of-life care symptoms. Ensuring frontline clinicians have ready access to standard protocols for end-of-life care and guidelines for managing symptoms (e.g. respiratory, delirium) of those dying due to COVID-19 infection will be important.

## Psychosocial, grief and bereavement support

It can be anticipated that the need for psychosocial support for patients, their families and caregivers will increase during the pandemic. Along with the usual sources of psychosocial distress, there will be heightened distress due to:

- Changing access to health care resources due to the pandemic

**Planning for Palliative Care Delivery during the COVID-19 Pandemic**

- Strained family care systems as a result of acute illness
- Limitations on visitation and direct contact with patients/residents who are in hospital or long term care
- Significant financial risks due to changes in the economy
- Challenges to accessing food in instances of self-isolation

Some of the key issues in planning will be:
- Establishing a regular triage function to identify patients and family in most need of psychosocial support and ensure optimal use of those with specialized skills.
- Identifying the key clinicians with expertise in providing psychosocial care and regularly review assignments to ensure most effective use of their expertise.
- A review of the human resource plan with a view toward reallocating some care providers to those support activities that can be accomplished with primary level competency and/or brief additional training. Refer to the Ontario Palliative Care Network's Palliative Care Competency Framework, which provides a comprehensive guide of the knowledge, attributes and skills providers need to deliver high-quality palliative care in Ontario. Available here: https://www.ontariopalliativecarenetwork.ca/en/competencyframework
- A review of visitation policies to ensure maximum contact between patients and families while at the same time ensuring appropriate infection control procedures.
- Planning for alternative approaches to support families where direct contact is not possible. This may include digital technologies to support contact among family member and alternative approaches to providing information and support to family members who are not able to enter an institution.
- Reviewing practices and protocols for managing care once a patient has died especially if that has occurred due to COVID-19

## Clinician safety and support

This will be a stressful time for health care providers and administrators. The pressures and stresses will come from workload, caring for a population that will have heightened anxiety, the risk of infection, reduced access to clinical consultation, pressures at home around childcare and/or financial constraints and others. Palliative care and frontline clinicians may feel additional pressures to advocate for the care of patients in a climate where a major focus is on managing acute illness due to COVID-19. Some of the key issues in planning will be:
- Ensuring in all settings that clinicians are knowledgeable about and practice the appropriate approaches to infection control and have access to personal protective equipment.
- Ensuring that clinicians have easy access to reliable and up-to-date information about the evolving pandemic.
- Ensuring that frontline clinicians have the best possible access to clinical advice and tools.
- Ensuring that clinicians are well-informed about regional, local and institutional planning and direction within their setting of practice.

March 24, 2020

## Planning for Palliative Care Delivery during the COVID-19 Pandemic

- Establishing regular opportunities for clinicians to debrief and receive support. This may be as a group but, there will need to be opportunities for one-on-one support when needed.
- Providing clinicians with access to resources for self-care. Refer to the OPCN's document *"Palliative Care Resources to Support Frontline Providers during the COVID-19 Pandemic"*

### References

1. Downar J, Seccareccia D. Palliating a Pandemic: "All Patients Must Be Cared For". J Pain & Symptom Management 2010; 39(2): 291-5.
2. A Guide to Pandemic Planning for Pediatric Palliative Care. Canadian Network of Palliative Care for Children; November 2015. https://www.chpca.ca/wp-content/uploads/2019/12/caring_for_children.pdf
3. Pandemic Planning Guideline for Patients with Cancer. Cancer Care Ontario; March 10, 2020.